IMPAIRMENT CERTIFICATE
(HEARING)

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES

I HEREBY REQUEST THAT 'HEARING IMPAIRED' BE NOTED ON MY OPERATOR'S LICENSE IN ACCORDANCE WITH PUBLIC ACT 83-491.

NAME

DATE OF BIRTH | CONNECTICUT LICENSE NUMBER

ADDRESS (NO., STREET) | (CITY/TOWN) (STATE & ZIP CODE)

I HEREBY CERTIFY THAT THE ABOVE NAMED PERSON IS A DEAF OR HEARING IMPAIRED PERSON.

NAME OF PHYSICIAN OR LICENSED AUDIOLOGIST | STATE LICENSE NO.

OFFICE ADDRESS

PERSONAL SIGNATURE OF PHYSICIAN OR AUDIOLOGIST | DATE SIGNED

X

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